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MEDICAID MEMO

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Implementation of Nursing Facility Price-Based Payment Methodology — REVISED

This memorandum (which supersedes the memo entitled "Implementation of Nursing Facility Price- Based Payment Methodology" dated June 9, 2014) is a *REVISION to the previous memo, which has been removed from the Web Portal*.

The purpose of this memo is to inform you of a new payment methodology for nursing facilities, effective July 1, 2014. Currently, Medicaid reimburses all nursing facilities for operating costs utilizing a facility-specific per diem rate that is set prospectively based on prior year costs. Effective for claims with dates of service on or after July 1, 2014, DMAS will pay nursing facilities using a new price-based payment methodology. The price-based methodology was developed in consultation with a Nursing Facility Medicaid Payment Workgroup composed of members from the Virginia Health Care Association (VHCA), the Virginia Association of Non-Profit Homes for the Aging (VANHA) and the Virginia Hospital and Healthcare Association (VHHA).

Payment for capital, nurse aide training and criminal records check will also be modified to make payment fully prospective. There are no changes to payment for specialized care except to incorporate similar modifications to capital reimbursement. There are also no changes to payment for state nursing facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) and the Department of Veterans Services (DVS).

The approved state fiscal year (SFY) 2015 budget adjusted the funding for capital reimbursement. The budget reduced the Fair Rental Value (FRV) rental rate to 8.0 percent in SFY 2015. The final rates and payments effective for dates of service on or after July 1, 2014 will reflect the reduced rental rate.

Price-Based Operating Rates for Direct and Indirect Costs

The Nursing Facility Price-Based Payment Methodology includes fully prospective operating rates for direct and indirect costs using costs from a base year inflated to the rate year,

adjusted for regional cost differences based on peer groups. The rate for direct costs is based on an adjustment factor of 105% of the Medicaid day- weighted median for freestanding nursing facilities by peer group and the rate for indirect costs is based on an adjustment factor of 100.7% of the Medicaid day-weighted median for indirect costs for freestanding nursing facilities by peer group. The initial base year is provider fiscal year costs in calendar year (CY) 2011.

The methodology also incorporates a "price-based spending floor." With the price-based spending floor, all facilities receive full price if costs, inflated to SFY 2015, are at or above 95% of the price. Facilities with projected costs below 95% of the price have a lower adjusted price equal to the price minus the difference

between their projected cost and 95% of the unadjusted price. By limiting the potential gain of low cost facilities, it is possible to implement higher adjustment factors for all facilities at a lower overall expenditure level and reduce the amount of transition losses for higher cost facilities. DMAS will continue to monitor and review the impact of the price-based spending floor provision.

Price-based rates will be increased annually by inflation forecast by IHS Global Insight unless modified by the General Assembly. DMAS will rebase operating rates in SFY 2018 and every three years thereafter using the most recent calendar year settled cost reports for freestanding nursing facilities for the base year.

See below for a description of the transition.

Revised Peer Groups

The peer groups for price-based payment calculations have been modified from the current peer groups. They are a combination of Medicare wage regions and Medicaid rural and bed size classifications based on similar costs.

- Direct Peer Groups

- Northern Virginia MSA
- Other MSAs
- Northern Rural
- Southern Rural

- Indirect Peer Groups
  - Northern Virginia MSA
  - Rest of State – Greater than 60 beds
    - Other MSAs
    - Northern Rural
    - Southern Rural
  - Rest of State – 60 Beds or Less

Case Mix Adjustment for the Direct Rate

Resource Utilization Group (RUG) is a resident classification system that groups nursing facility residents according to resource utilization and assigns weights related to the resource utilization for each classification. The department shall use RUGs to determine facility case mix for cost neutralization in determining the direct costs used in setting the price and for adjusting the claim payments for residents. Initially, DMAS will continue to use the RUG III – 34 Medicaid grouper and associated weights. DMAS with input from the Nursing Facility Medicaid Payment Workgroup will consider implementing RUG IV – 48 Medicaid grouper and associated weights in the future.

Under the current methodology, facility direct costs are neutralized and adjusted by case mix, which is normalized every quarter to a statewide 1.0 case mix. Case mix changes are reflected only in the growth in facility costs. With the adoption of the price-based methodology, case mix will no longer be normalized so that changes in case mix will be immediately reflected in changes in reimbursement. Direct costs were neutralized by non-normalized (raw) facility case mix before determining the median day weighted costs to reflect the change to price-based payment adjusted by raw case mix on each claim.

For claims with dates of service between July 1, 2014 and October 31, 2014, facility direct rates will be case mix adjusted using the average facility case mix from the two most recent finalized quarters (September and December 2013) instead of adjusting this component claim by claim. For dates of service on or after

November 1, 2014, the direct rate component will be adjusted on each claim by the resident's current Medicaid RUG score (similar to the determination of Medicare rates).

Transition

There will be a four-year transition to the new price-based payment system. Rates will be a blend of the facility's current cost-based rate and new price-based rate in 25% increments. The cost-based rate component will be prospectively established based on the current cost-based methodology using the PFY11 cost reports adjusted for neutralization and inflated to the rate period. Current cost-based rates include a facility case mix adjustment for the direct cost component. DMAS will remove the case mix adjustment from the direct cost component of the cost-based rate because the case mix adjustment will be determined on an individual claim basis. Based on a four-year transition, the rate will be based on the following blend:

1. FY15 – 25% of the price-based rate and 75% of the cost-based rate
2. FY16 – 50% of the price-based rate and 50% of the cost-based rate
3. FY17 – 75% of the price-based rate and 25% of the cost-based rate
4. FY18 – 100% of the price-based (fully implemented)

During the first transition year for the period of July 1, 2014 through October 31, 2014, DMAS will case mix adjust each direct cost component of the rates using the average facility case mix from the two most recent finalized quarters (September and December 2013) instead of adjusting this component on a claim-specific basis.

Cost-based rates to be used in the transition for facilities without cost data in the base year but placed in service prior to July 1, 2013 shall be determined based on the most recently settled cost data. If there is no settled cost report at the beginning of a fiscal year, then 100% of the price-based rate shall be used for that fiscal year. Facilities placed in service after June 30, 2013 shall be paid 100% of the price-based rate.

Prospective Rates for Capital, NATCEPs (Nurse Aide Training and Competency Evaluation Program), and Criminal Records Checks

DMAS will continue to pay freestanding nursing facilities for its capital costs through FRV

but DMAS will implement a process to make the FRV rates fully prospective with the state fiscal year rate period. In order to do this, providers will be required to submit calendar year FRV reports. FRV rates for the upcoming fiscal year will be based on the prior calendar year information aged to the state fiscal year and using RSMeans factors and rental rates corresponding to the fiscal year. The rental rate floor for SFY 2015 is 8.0%.

DMAS will make mid-year FRV rate adjustment for new beds or a major renovation. A major renovation is defined as a capital expenditure of at least $3,000 per bed. The nursing facility shall submit a complete pro forma documentation at least 60 days prior to the effective date and the new rate shall be effective at the beginning of the month following the end of the 60 days. The provider shall submit final documentation within 60 days of the new rate effective date and the department shall review final documentation and modify the rate if necessary effective 90 days after the implementation of the new rate. No mid-year rate changes shall be made for an effective date after April 30 of the fiscal year.

Hospital-based nursing facilities are not paid for capital costs based on FRV but their reimbursement is based on capital depreciation. DMAS will pay the last settled capital rate for these facilities.

Prospective NATCEP rates shall be the Medicaid per diem rate in the base year inflated to the rate year based on inflation used in the operating rate calculations. A prospective rate for criminal records checks shall be the per diem rate in the base year.

Billing Changes

Initially, there will be no billing changes. For dates of service on or after November 1, 2014, there will be billing changes that will require facilities to submit RUG scores on the claim. The Medicaid process will be a simplified version of the process used by Medicare and will use the Medicaid RUG III-34 grouper. Additional billing guidance will be published in a Medicaid Memo in September.

Rate Posting and Questions

Rates and Frequently Asked Questions (FAQs) have been posted to the DMAS website at www.dmas.virginia.gov under Provider Services, Rate Setting Information, Nursing Facilities or the rate setting home page at http://www.dmas.virginia.gov/Content_pgs/pr-rsetting.aspx under Nursing Facilities. Separate facility rates for July 1, 2014 to October 31, 2014 and for November 1, 2014 to June 30, 2015 are posted. If you have any questions regarding changes to the nursing facility payment methodology, including changes to FRV, you may contact DMAS at the following address NFPayment@dmas.virginia.gov.

MANAGED CARE ORGANIZATIONS

Many Medicaid recipients are enrolled with one of the Department's contracted Managed Care Organizations (MCO). In order to be reimbursed for services provided to an MCO enrolled individual, providers must follow their respective contract with the MCO. The MCO may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the MCO directly. Additional information about the Medicaid MCO program can be found at http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx.

COMMONWEALTH COORDINATED CARE

Commonwealth Coordinated Care (CCC) is a new initiative to coordinate care for individuals who are currently served by both Medicare and Medicaid and meet certain eligibility requirements. Please visit the website at http://www.dmas.virginia.gov/Content_pgs/altc-home.aspx to learn more.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Helpdesk, toll free, at

1-866-352-0496 from 8:00

a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access service authorization information including status via KEPRO's Provider Portal at http://dmas.kepro.com.

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273 Richmond area and out-of-state long distance

1-800-552-8627 All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.